

Case Number:	CM15-0059455		
Date Assigned:	04/06/2015	Date of Injury:	07/27/2013
Decision Date:	05/27/2015	UR Denial Date:	02/18/2015
Priority:	Standard	Application Received:	03/30/2015

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 34-year-old female, with a reported date of injury of 07/27/2013. The mechanism of injury was not provided. The diagnoses include cervical disc protrusion, lumbar radiculopathy, cervical radiculopathy, and lumbar sprain/strain. Treatments to date include physical therapy and oral medications. The progress report dated 01/29/2015 indicates that the injured worker complains of neck pain with numbness and tingling, and low back pain and stiffness with numbness and tingling. The pain was rated 8 out of 10. The objective findings include decreased cervical spine range of motion, tenderness to palpation of the cervical paravertebral muscles and spinous process, muscle spasm of the bilateral trapezius and cervical paravertebral muscles, decreased lumbar spine range of motion, tenderness to palpation of the bilateral sacroiliac joint, coccyx, lumbar paravertebral muscles, sacrum, and spinous processes, muscle spasm of the bilateral gluteus and lumbar paravertebral muscles, bilateral pain with straight leg raise test, and a slight antalgic gait. The treating physician requested mechanical traction therapy, an ultrasound, diathermy, electrical stimulation, therapeutic exercises, myofascial release, chiropractic manipulative treatment, infrared therapy, cap patches, and one or more needles.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Mechanical Traction Therapy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Traction.

Decision rationale: The Official Disability Guidelines indicate home based injured worker controlled gravity traction may be a noninvasive conservative option if used as an adjunct to a program of evidence based conservative care. The clinical documentation submitted for review failed to provide documentation to support the use of the traction unit. There was a lack of documentation indicating the body part to be treated with the traction unit. The request as submitted failed to indicate the body part and the frequency/duration. Given the above, the request for mechanical traction therapy is not medically necessary.

Ultrasound: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ultrasound, therapeutic Page(s): 123.

Decision rationale: The California MTUS Guidelines do not recommend the use of therapeutic ultrasound. There was a lack of documented rationale for the use of the therapeutic ultrasound. The request as submitted failed to indicate the body part and the frequency/duration. There was a lack of documentation of exceptional factors to warrant non-adherence to guideline recommendations. Given the above, the request for ultrasound is not medically necessary.

Diathermy (electrically induced heat): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Diathermy.

Decision rationale: The Official Disability Guidelines indicate that diathermy is not recommended. The rationale was not provided. The request as submitted failed to indicate the body part and the frequency/duration and whether the unit was for rental or purchase. Given the above, the request for diathermy electrically induced heat is not medically necessary.

Electrical Stimulation: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Electrical stimulators (E-stim) Page(s): 45.

Decision rationale: The California MTUS Guidelines indicate that some types of electrical stimulators are recommended; however, the documentation submitted for review failed to provide documentation of the specific type of E stimulation being requested. The request as submitted failed to indicate the body part and the frequency/duration. Given the above, the request for electrical stimulation is not medically necessary.

Therapeutic Exercises: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM,Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98, 99.

Decision rationale: The California MTUS Guidelines recommend physical medicine treatment for myalgia and myositis for up to 10 visits. The clinical documentation submitted for review failed to provide documentation of objective functional deficits to support the necessity for therapeutic exercise. The request as submitted failed to indicate the body part and the frequency/duration. Given the above, the request for therapeutic exercises is not medically necessary.

Myofascial Release 1-2 times weekly for 4 weeks for Cervical, Thoracic and Low Back Region: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM,Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Massage therapy Page(s): 60.

Decision rationale: The California MTUS Guidelines recommend massage therapy for up to 4 to 6 visits; however, they further indicate beneficial effects were registered only during treatment. The clinical documentation submitted for review failed to provide documentation of exceptional factors to warrant non-adherence to guideline recommendations and beneficial effects were only registered during treatment. Given the above, the request for Myofascial Release 1-2 times weekly for 4 weeks for Cervical, Thoracic and Low Back Region is not medically necessary.

CMT (Chiropractic manipulative treatment) Spinal 1-2 Regions 1-2 times weekly for 4 weeks for Cervical, Thoracic and Low Back Region: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 173, 298-299, Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-59.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy Page(s): 58, 59.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines states that manual therapy and manipulation is recommended for chronic pain if caused by musculoskeletal conditions. For the low back, therapy is recommended initially in a therapeutic trial of 6 sessions and with objective functional improvement, a total of up to 18 visits over 6 to 8 weeks may be appropriate. Treatment for flare-ups requires a need for re-evaluation of prior treatment success. Treatment is not recommended for the ankle & foot, carpal tunnel syndrome, the forearm, wrist, & hand or the knee. If chiropractic treatment is going to be effective, there should be some outward sign of subjective or objective improvement within the first 6 visits. Treatment beyond 4 to 6 visits should be documented with objective improvement in function. The clinical documentation submitted for review failed to indicate a necessity for up to 8 sessions of chiropractic treatment. Given the above and the lack of documentation of exceptional factors, the request for CMT (Chiropractic manipulative treatment) Spinal 1-2 Regions 1-2 times weekly for 4 weeks for Cervical, Thoracic and Low Back Region is not medically necessary.

Infrared Therapy: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Infrared therapy (IR).

Decision rationale: The Official Disability Guidelines indicate that infrared therapy is not recommended over other heat therapies. The rationale was not provided. The request as submitted failed to indicate the body part and the frequency/duration. There was a lack of documentation of exceptional factors to warrant non-adherence to guideline recommendations. Given the above, the request for infrared therapy is not medically necessary.

Cap Patches 8%: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Capsaicin Page(s): 111, 28.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines indicate that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety "are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed...Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended" Capsaicin: Recommended only as an option in patients who have not responded or are intolerant to other treatments. There have been no studies of a 0.0375% formulation of capsaicin and there is no current indication that this increase over a 0.025% formulation would provide any further efficacy. The clinical documentation submitted for review failed to provide documentation of a trial and failure of antidepressants and anticonvulsants. There was a lack of documentation of exceptional factors to warrant non-adherence to guideline recommendations. The request as submitted failed to indicate the body part to be treated, the frequency, and the quantity of patches being requested. Given the above, the request for cap patches 8% is not medically necessary.

1 Or More Needles, 15 Minutes And 1 Or More Needles, Re-Insertion Of Needles, 15 Mins: 1-2 times weekly for 4 weeks for Cervical, Thoracic and Low Back Region: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 173, 298-299, Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines state that acupuncture is used as an option when pain medication is reduced or not tolerated and it is recommended as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Acupuncture can be used to reduce pain, reduce inflammation, increase blood flow, increase range of motion, decrease the side effect of medication-induced nausea, promote relaxation in an anxious patient, and reduce muscle spasm. The time to produce functional improvement is 3 to 6 treatments. The clinical documentation submitted for review failed to provide documentation that pain medication was reduced or not tolerated. There was a lack of documentation of exceptional factors to warrant non-adherence to guideline recommendations. The time to produce improvement is 3 to 6 treatments. The request for 8 sessions would be excessive. Given the above, the request for 1 Or More Needles, 15 Minutes and 1 Or More Needles, Re-Insertion of Needles, 15 Mins: 1-2 times weekly for 4 weeks for Cervical, Thoracic and Low Back Region is not medically necessary.

Sleep Number Bed: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medicare National Coverage Determinations Manual: Chapter 1 Part 4; Official Disability Guidelines: Knee & Leg chapter - Durable Medical Equipment (DME).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Mattress Selection, Knee & Leg Chapter, Durable Medical Equipment (DME).

Decision rationale: The Official Disability Guidelines indicate that mattress selection is the injured worker's choice. However, a bed would need to meet durable medical equipment guidelines. The Official Disability Guidelines indicate that durable medical equipment is appropriate when there is documentation that the requested item meets Medicare's criteria including can be rented and used by successive patients, is primarily and customarily used to serve a medical purpose, is generally not useful to an injured worker in the absence of illness or injury, and is appropriate for use in the injured worker's home. The clinical documentation submitted for review failed to meet the above criteria. A bed is not primarily and customarily used to serve a medical purpose and it is useful to an injured worker in the absence of illness or injury. Given the above, the request for a Sleep Number bed is not medically necessary.